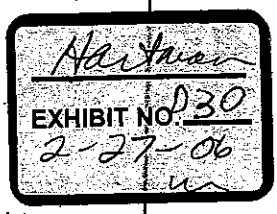
Exhibit 45

UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS



No. 01CV12257-PBS

****

IN RE: PHARMACEUTICAL INDUSTRY *
AVERAGE WHOLESALE PRICE LITIGATION *

****

DEPOSITION OF JILL S. HERBOLD, taken pursuant to the Federal Rules of Civil Procedure, at CIGNA Headquarters, 900 Cottage Grove Road, South Building, Bloomfield, CT, before Diana M. Noel, a Registered Professional Reporter, Certified Realtime Reporter, and Licensed Shorthand Reporter No. 199, in and for the State of Connecticut, on Friday, January 14, 2005, commencing at 12:48 PM.

2

APPEARANCES:

FOR THE PLAINTIFFS:

EDWARD NOTARGIACOMO, ESQUIRE (By Telephone)
HAGENN BERMAN
One Main Street
Fourth Floor
Cambridge, MA 02141
Tel: (617) 482-3700

FOR THE DEFENDANTS:
ESTELLA J. SCHOEN, ESQUIRE
PATTERSON, BELKNAP, WEBB & TYLER, LLP
1133 Avenue of the Americas
New York, NY 10036-6710
Tel: (212) 336-2000
e-mail: eschoen@pbwt.com

FOR CONNECTICUT GENERAL LIFE INSURANCE COMPANY AND THE DEPONENT, JILL S. HERBOLD:
PETER D. ST. PHILLIP, JR., ESQUIRE
LOWEY DANNENBERG BEMPORAD & SELINGER, P.C.
The Gateway
One North Lexington Avenue
White Plains, NY 10601
Tel: (914) 997-0500
e-mail: pstphillip@ldbs.com
and
MICHAEL WADE, ESQUIRE
Counsel - Legal & Public Affairs
CIGNA
900 Cottage Grove Road, S201
Hartford, CT 06152-5026
Tel: (860) 226-2457
e-mail: michael.wade@cigna.com

3

INDEX OF EXAMINATION

4

JILL S. HERBOLD
having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION
BY MS. SCHOEN:
Q. Can you please state your name for the record.
A. Jill Herbold.
Q. Can you spell your last name.
A. It's H E R B O L D.
Q. Ms. Herbold, my name Estella Schoen. I introduced myself briefly before the deposition started. I'm with the firm of Patterson, Belknap, Webb & Tyler, and we represent the Defendants in this matter, and I'll be asking you asking you some questions today.
Can you tell me if you've ever been deposed before?
A. I have not.
Q. To start out, we'll just go over a few ground rules for the deposition which you may have gone over

5

with your counsel.
If you have any question or don't understand a question that I have for you, please just let me know, and I'll try to rephrase the question or explain it to you.
Also, if I ask you a question, and -- it's best to respond verbally so the court reporter can take it down as it's difficult for her to take down a nod of the head or a shake of the head.
A. Yes.
Q. And if you'd like to take a break, please just let me know, and we can take one.
Do you understand, Ms. Herbold, that you are here today speaking on behalf of Cigna?
A. Yes.
Q. And can you tell me what you've done to prepare for giving testimony today?
MR. ST. PHILLIP: Without going into any conversations we had, you can tell her what you've done.
A. I have just been doing my job, and I have also met with our legal counsel.

6

Q. Besides speaking with your legal counsel, did you speak with anyone else at Cigna in preparation for your testimony today?
A. Yes, I did. I spoke with one person that has knowledge of the topics prior to me becoming involved in these topics.
Q. Can you tell me what your current position is at Cigna?
A. I'm responsible for strategy and policy as well as financial analysis for practitioner reimbursement.
Q. And is that -- do you have a formal title?
A. Yes. Assistant Vice President Practitioner Reimbursement.
Q. How long have you held the position of Assistant Vice President for Practitioner Reimbursement?
A. Since February 2004.
Q. And how long have you been employed by Cigna?
A. Since August 1993.
Q. Just to get a little background, can you tell me about your educational history after high school.

7

A. Yes. I have a Bachelor's degree in actuary sciences from the University of Illinois.
Q. And can you tell me generally about your work history after college but prior to coming to Cigna?
A. I came to Cigna directly from college.
Q. And can you tell me in 1993, when you first came to Cigna, what was your position?
A. I was an actuarial student.
Q. For how long were you an actuarial student?
A. Three years.
Q. And so in approximately 1996, you shifted positions?
A. Yes. At that time I became a fellow of the Site of Actuaries, and so I had completed -- I had finished being a student at that point and just have done actuarial positions since then.
Q. So in 1996, your title shifted to -- do you know what your new title was?
A. Associate Actuary perhaps.
Q. Can you tell me approximately how long you were an Associate Actuary?
A. Two years perhaps.

8

Q. So in approximately 1998, you shifted into a different position?
A. Yes. I believe it was called Assistant Actuary.
Q. And how long were you the assistant or an assistant actuary?
A. Until 2001.
Q. And in 2001, did you -- were you given a new title?
A. Yes. Assistant Vice President in Actuary.
Q. And for how long did you hold the position of Assistant Vice President in Actuary?
A. I still do.
Q. And so are you -- do you have two titles? One is Assistant Vice President of Actuary and one is Assistant Vice President Practitioner Reimbursement, or --
A. To clarify, technically my title is Assistant Vice President in Actuary right now. However, what I oversee is practitioner reimbursement, so actuary is my credentials.
Q. So your title is Assistant Vice President in

9

Actuary, but you have responsibility for Practitioner Reimbursement?
A. That's correct.
Q. Can you tell me what other -- can you describe your responsibilities as they currently exist as Assistant Vice President in Actuary?
A. Yes. My current responsibilities are for practitioner reimbursement, strategy and policy, for the financial analysis associated with practitioner reimbursement, as well as the operational loading of our contracts with practitioners.
Q. Are you involved in negotiations with practitioners?
A. Not on a routine basis.
Q. But occasionally you would be?
A. From time to time, yes.
Q. Since 2001, have those been your responsibilities?
A. No.
Q. Can you tell me --
A. Those have been my responsibilities since February of 2004.

10

Q. Can you tell me what your responsibilities were from 2001 through 20 -- through February of 2004?
A. Yes. I had a few different responsibilities during that time period. They were all financial in nature. One of those responsibilities was related to the analysis of contracts with hospitals. Another one related to the analysis of our national contracts with national vendors.
Q. National vendors of what?
A. Of ancillary services such as laboratory services and home healthcare, and another responsibility was around the analysis of practitioner reimbursement.
Q. When you did analysis of practitioner reimbursement during that time period, can you tell me what you were looking for?
A. The basic function, which I still oversee today, is to analyze proposed changes in our contracts with physicians to understand the financial impact to the organization.
Q. And can you tell me at what point in the negotiations with physicians do you -- does your

11

analysis play a role? For example, does it play a role at the starting point, at the mid point, at the deciding on a final contract, or something else?
A. It can play an impact at any one of those points.
Q. From 1998 through 2001, when you were an Assistant Actuary, can you tell me a little bit about your responsibilities then?
A. I was responsible for pricing of our PPO line of business.
Q. Pricing to your clients like employers?
A. Setting trends and manual rates.
Q. To your employers -- I'm sorry, to your clients?
A. Setting -- the manual rates are used to set the rates with clients, but there's also an underwriting process that's taken into account, so an underwriter would use my manual rates to determine the final rate to the client.
Q. Did your roles and responsibilities from 1998 to 2001 involve looking at reimbursement to physicians?
A. No.

12

Q. Just going backwards in time, from 1996 to 1998, when you were an associate actuary, can you tell me a little bit about your responsibilities in that role?
A. Uh-hum. I was the pricing actuary for our Medicare risk line of business that we had at the time. And I also spent a year in corporate finance.
Q. Did any of your roles and responsibilities from 1996 to 1998 involve looking at or involve in any way reimbursement to physicians?
A. No.
Q. Did it involve in any way reimbursement to hospitals?
A. No.
Q. Can you tell me briefly about your roles and responsibilities from 1993 through approximately 1996, when you were an actuarial student?
A. Yes. I worked in the defined contribution pricing area in the retirement and investment business. I also worked in -- it was doing financial projections for two different lines of business in the healthcare area, and those projections were gross revenues as well

13

as net underwriting gain.
Q. Did any of the work that are your responsibilities from 1993 through 1996 involve looking at reimbursements to physicians?
A. No.
Q. Did it involve looking at reimbursements to hospitals?
A. No.
Q. So would I be correct to say that you had not been involved in reimbursement or payments to physicians for their services until 2001?
A. That's correct.
Q. And do you have an understanding of how providers physicians have been reimbursed by Cigna for pharmaceutical products that are administered in a physician's office?
MR. ST. PHILLIP: Objection to form.
You can answer. I may object, and when I do that, I'm just creating a place holder in the record for an objection that may be decided later by a court or by someone else. So when I intervene and say objection, then

14

after that you can either answer -- you can answer the question. The other thing I may do is instruct you not to answer, and then you can decide whether or not you're going to answer by instruction.

A. Could you please repeat the question?

Q. Sure.

Do you have an understanding of how Cigna has reimbursed physicians for pharmaceutical products that are administered in a physician's office from the period of 1991 to the present?

A. I have knowledge during part of that time period.

Q. Can you tell me which part?

A. Since 2001.

Q. Since 2001, can you tell me how Cigna has reimbursed physicians for pharmaceutical products administered in their office?

A. The reimbursement has been done per the contracting terms.

Q. How are the contract terms established?

A. Contract terms are frequently established via

15

negotiations with the provider groups. They may also be established for physicians -- well, using our standards for physicians that we actually don't have negotiations with.

Q. So just to make sure I understand, you're saying in some cases you would go through a negotiation process with a physician or a physician group, but in other cases, the physician or physician group would accept a standard Cigna contract?

A. That's correct.

Q. And where in this contract -- strike that.

Would the contract contain the reimbursement that a physician would receive for a pharmaceutical product administered in the physician's office?

A. Yes.

Q. So that would be in the terms of the contract, or would it be in a fee schedule or a compensation schedule?

A. The way it is typically done is there is a rate exhibit attached contract. I believe that it technically may become a part of the contract.

16

Q. And the rate exhibit, that would contain the reimbursement rate for services and -- services of the physician?

A. That is correct.

Q. And it would also contain the rates for reimbursement of pharmaceutical products administered in the physician's office?

A. That's correct.

Q. And the rate exhibit would vary by physician's practice? In other words, there are many different rate exhibits for the different physician practices that Cigna contracts with?

A. That is correct.

Q. And is the variation in the rate exhibits due to the negotiation process that you described earlier with the physicians?

A. That is correct.

Q. For pharmaceuticals that Cigna would reimburse that have been administered in the physician's office, would the rate exhibit contain a line item for each particular pharmaceutical product, or would it group pharmaceutical products together in

17

some way?

A. Generally it would group pharmaceutical products together.

Q. And do you know if reimbursement for pharmaceutical products may, in some cases at least, be reimbursed based on some industry benchmark?

MR. ST. PHILLIP: Objection.

A. Yes. If that is what was negotiated.

Q. So in some cases, the negotiations may yield a reimbursement rate that is based on a industry benchmark, but in other cases it would not?

MR. ST. PHILLIP: Objection.

A. Yes.

Q. Do you know what industry benchmarks -- benchmark or benchmarks may be used?

A. Average wholesale price is the typical. I do not recall seeing any other contracts that use industry benchmarks -- use anything but average wholesale price.

Q. If the reimbursement rate for physicians for pharmaceuticals is not expressed as a -- as in relation to the average wholesale price, how else would it be expressed in the contract?

18

A. Sometimes it is expressed that we -- the reimbursement will be per Cigna's national standard injectable reimbursement, and on occasion, it could be specified that the reimbursement is based on a percent of the billed charges.
Q. Can you tell me approximately in what percent of cases would the reimbursement be based on the AWP benchmark that you just described?
MR. ST. PHILLIP: What time period are we talking about?
MS. SCHOEN: Well, we were talking about since 2001, because the witness testified that prior to that she was not sure of the methodology.
A. Since the 2001 time period, we put a change into effect and established that national standard in January of 2002, and since that time, I believe approximately half of the reimbursement has been based like AWP standards versus approximately half according to our national standards.
Q. And you mentioned another option which is a percentage of billed charges?

19

A. Very small.
Q. Can you tell me how Cigna's national standard injectable reimbursement rate is set?
A. It is a complex setting. This will take a few minutes.
Q. You can tell me -- I guess to start, maybe to try to simplify it -- just the broad factors that go in or the sources Cigna uses if that helps at all.
A. The -- for many of the HCPCS codes that are included within the scope of injectables, we start looking at the average wholesale price, and to some of those we will set the reimbursement at equal to the average wholesale price. Others, we will reimburse less than the average wholesale price.
And there are other codes, approximately -- I believe it's 13 codes -- which, since September 7th of 2004, we have -- we changed the reimbursement methodology, and to set the fees on those codes, we are using physician acquisition costs as well as AWP.
Q. And that's for 13 pharmaceutical products?
A. 13 HCPCS codes.

20

Q. And how did that correspond with the pharmaceutical products?
A. It is my understanding, without having pharmacy expertise, that -- pharmaceutical products are each assigned an NDC, National Drug Code, I believe, and there are multiple NDCs that may be billed under a HCPCS code.
Q. Like a J-code?
A. Yes. A J-code is a HCPCS code.
Q. So for 13 J-codes since September 7, 2004, Cigna has been using the alternate methodology that you just described?
A. That is correct.
Q. Now, putting aside those 13 J-codes, Cigna has had its national standard injectable reimbursement rate since January of 2002, and would there be any other factors that Cigna would consider in setting the reimbursement rate for the remainder of the drugs?
A. No.
Q. So you described to me that Cigna would look at the code and sometimes would set it at the AWP, sometimes would set it at a percentage less than AWP --

21

A. Yes. The percentages were fixed. They varied by code, but they are fixed. They don't change from time to time.
Q. So for a particular code, Cigna would choose a percentage AWP and stick with that percentage?
A. That's correct, unless we decided there is appropriate reason to change it.
Q. Can you tell me the range below AWP that these rates and the Cigna national standard injectable reimbursement rate was varied?
A. Typically 15 percent. We have codes that are up to 45 percent below AWP.
Q. And you mentioned, I believe, that some J-codes may be set at average wholesale price?
A. That is correct.
Q. Can you tell me what accounts for this -- the variation in the reimbursement rate?
MR. ST. PHILLIP: Objection.
You can answer.
A. The variation is based on what we can or what our subsidiary is willing and able to provide the service to our members for.

22

Q. When you say the subsidiary, what do you mean?
A. It's a Cigna subsidiary.
Q. Are you referring to the Cigna subsidiary that would be providing the health plan services to the members?
A. The Cigna subsidiary that provides pharmaceutical services.
Q. Does that subsidiary have a name?
A. Tel-Drug.
Q. So why would -- strike that.
Why is Tel-Drug deciding what the reimbursement rate should be as opposed to another part of Cigna?
A. The physicians, rather than acquiring the injectable themselves, they can instead get it from Tel-Drug and still administer it in their office, and Tel-Drug will bill Cigna directly for the service. So the physician never has to worry about paying or receiving reimbursement for the injectable.
Q. So what if a physician wanted to purchase the drug himself and seek reimbursement from Cigna? Would

23

one mean the reimbursement would be the Cigna national standard injectable reimbursement rate?
A. That would be one potential, yes.
Q. It could be in the contract between Cigna and that particular provider?
A. Uh-hum, yes.
Q. So beyond considering what Tel-Drug is willing to provide in terms of reimbursement, are there any other factors that go into the variation between the different reimbursement rates under Cigna's national standard injectable reimbursement rate?
A. No. As we're specifically talking about the codes outside the approximate 13?
Q. Uh-hum.
A. It's for everything but those 13 codes. That is all that is considered.
Q. And who makes that decision at Tel-Drug?
A. I do not know.
Q. And do you know how Tel-Drug makes the decision of being willing to expect reimbursement at AWP for some drugs and at 45 percent below AWP for other drugs?

24

A. No.
Q. And Tel-Drug is a -- as you said, it's a subsidiary of Cigna?
A. That's correct.
Q. So I just want to make sure I understand since it's seems a little complicated.
So if a physician receives a pharmaceutical product through Tel-Drug, they use Tel-Drug to obtain the product. From what you've told me, I understand that Tel-Drug will provide that product to the physician, and Tel-Drug will then seek reimbursement for that product from Cigna?
A. That's correct.
Q. And Cigna will reimburse Tel-Drug?
A. That's correct.
Q. Do you know if the variation in the rates that Tel-Drug is willing to accept for reimbursement relate to Tel-Drug's -- relate to the cost of Tel-Drug's acquisition of the product?
A. I do not know.
Q. So if I wanted to understand Tel-Drug's reasoning, I would have to ask someone at Tel-Drug, I

25

presume, or is there someone in your group at Cigna that could tell me that?
MR. ST. PHILLIP: Objection.
A. There is not someone in my group.
Q. And you don't know who I would talk to at Tel-Drug, or what department?
A. Department would be Pharmacy Operations.
Q. And in talking about Tel-Drug's provision of their pharmaceutical products to physicians, are we talking about a specialty pharmacy service that Tel-Drug provides?
A. Could you clarify your question?
Q. Are you familiar with the term specialty pharmacy?
A. Not well enough to answer your question.
Q. Do you know if Cigna has a specialty pharmacy?
A. I have seen announcements.
MR. ST. PHILLIP: I guess I would object insofar as I don't think the witness understands what you mean by definition of a specialty pharmacy.

26

But you can answer.
A. There is an area in Cigna that is getting into specialty pharmacy. Exactly what specialty means, I do not understand.
Q. Going back to the rate exhibits that we were discussing previously, you had testified that approximately 50 percent of the reimbursement rates for pharmaceuticals dispensed in a physician's office would be based on AWP --
MR. ST. PHILLIP: Objection.
Q. -- is that correct?
A. That is correct.
Q. And can you tell me would those rates be typically set at AWP or at a percentage off AWP or at a percentage above AWP?
MR. ST. PHILLIP: In terms of -- we went through this a little bit on the pharmacy side, but in terms of the prevailing rates in the contracts today or historical rates?
MS. SCHOEN: I think we're limited from 2001 to the present, so that's what I'm talking about.

27

MR. ST. PHILLIP: And I would ask the witness to go back to '91 to the extent she knows or has acquired information about that or has acquired information about that --
MS. SCHOEN: I think for now, since she testified her knowledge is primarily from 2001 to now, we'll start there --
MR. ST. PHILLIP: Fair enough.
MS. SCHOEN: -- and then I can go back and explore if there's any bits of knowledge prior to that.
Q. So from the period from 2001 to the present, I believe you had testified that 50 percent approximately of the rate exhibit would base reimbursement for pharmaceutical products dispensed at a physician's office on the AWP; is that correct?
A. Yes.
Q. And can you tell me if that reimbursement rate would be set at the average wholesale price, above the average wholesale price, or below?
A. It can be set at any of those levels.
Q. And can you tell me what determines the

28

variation between those different levels? Would this be based on, for example, negotiations with the physician groups?
A. That is exactly what it's based on.
Q. So some physician groups would perhaps have more bargaining power and demand higher reimbursement rates for pharmaceutical products, and some may demand -- have lesser demands?
A. That is correct.
Q. Is it also the case that a physician's group, in negotiations with Cigna, may seek higher reimbursement for pharmaceutical products in exchange for WAC reimbursement in a whole other area of the fee schedule of the rate exhibit?
MR. ST. PHILLIP: Objection to form. You can answer.
A. Could you rephrase the question.
Q. Sure. Let me ask it in a different way, and maybe it will be clear.
When Cigna negotiates with a physician's group, are you negotiating the entire rate schedule or rate exhibit as a whole, or are you negotiating it on a

29

piecemeal basis?
A. The negotiation is completed in whole, so negotiating all the physician's services.
Q. So would it be correct to say that in some cases a physician might accept a lesser reimbursement for pharmaceutical products and instead demand a greater reimbursement for a particular service, for example?
A. That can definitely happen.
Q. And can you tell me the range that would exist if I were to be able to look at all the rate exhibits that Cigna has out there, the range and AWP reimbursements that may exist?
A. Can you clarify your question? Are you talking about all of Cigna's rate exhibits or the rate exhibits that are based on AWP?
Q. Thank you. We're talking about all of the rate exhibits that are based on AWP.
A. I do not have enough knowledge to tell you what the rate is.
Q. Can you give me a rough estimate?
A. My rough estimate would be between 80 and

30

120.
Q. And the variation between the 80 and 120 would be due to variability in the negotiation process with physicians?
A. That's correct.
Q. In your experience, do certain groups of physicians command higher reimbursement rates than others -- for example, oncologists?
A. There are certain physician groups that do demand higher rates than other groups.
Q. When you go into negotiations with physicians, how does Cigna decide whether the baseline will be the AWP based reimbursement that you've described or the Cigna national standard injectable reimbursement that you've described?
A. It is a standard to use the Cigna national standard. The reimbursement, other than the Cigna national standard, is only on an exception basis.
Q. So would it be correct to say that Cigna would like you to use its national standard rates in all negotiations and only does not use those if the physicians' groups object?

31

MR. ST. PHILLIP: Object.
A. Yes.
Q. And why would a physician group, if you know, why would a physician group object to the use of Cigna's national standard rates?
A. Because they feel the reimbursement is inappropriate.
Q. If -- does Cigna ever negotiate variations from its national standard rates? In other words, would Cigna ever present its rates to a physician as a national standard rate, and the physician and Cigna could negotiate from those rates or down from those rates?
A. Not -- the negotiation does not take place that we negotiate at a percent of our national standard. That we do not do.
Q. So if Cigna has a contract with a physician's group, and that rate exhibit incorporates Cigna's national standards rate, there would be no variation and -- strike that.
So if a physician's group accepts Cigna's national standard rates, it is not free to then

32

negotiate with Cigna to change those rates in any way; it must accept those as is?
MR. ST. PHILLIP: Objection.
Q. Is that correct?
A. If he accepts them, he accepts them. If he doesn't accept them, he negotiates otherwise.
Q. I'm comparing -- this may be a more helpful way to get to where I'm going. Maybe I'm comparing it to the AWP example where, as I understand it from you, there is negotiation that results in different reimbursement rates.
MR. ST. PHILLIP: Objection.
A. Yes.
Q. So comparing to -- how does Cigna's use of its national standard injectable rates compare to --
(Discussion off the record.)
Q. Let me try this in a new way.
Is Cigna's national standard injectable reimbursement rate a take it or leave it proposition? In other words, there's no negotiation on those rates?
A. When they accept the national standard, they've accepted it. If they want to negotiate

33

otherwise, negotiations can happen.
Q. Do they happen on the basis of the national standard injectable rates or not?
A. Typically not.
Q. At that point, if a physician's group wants to negotiate the reimbursement rate it receives for pharmaceuticals products, then that negotiation would take place with a baseline of AWP, is that right?
MR. ST. PHILLIP: Objection to form.
You can answer.
A. That would be very common.
Q. If I were to go out and look at all of Cigna's rate exhibits, would I find anywhere -- I would see the Cigna's national standard injectable reimbursement rates minus 10 percent set as the reimbursement rate?
A. Not to my knowledge.
Q. Or minus any percentage?
A. No, not to my knowledge.
Q. Plus any percentage?
A. Not to my knowledge.
Q. You mentioned that there's a small amount of

34

reimbursement to physicians that's based on a percentage of billed charges?
A. That is correct.
Q. Can you tell me why Cigna reimburses based on billed charges in a small number of cases?
MR. ST. PHILLIP: Objection.
You can answer.
A. Part of the negotiation process.
Q. Would I be correct in assuming that in that negotiation process, it would be the physician who wanted to be reimbursed at a percentage of their billed charges?
MR. ST. PHILLIP: Objection.
A. Yes.
Q. I want to turn back to what -- to your testimony earlier where you testified that there are 13 J-codes, that since September 7, 2004, have been reimbursed using the different methodologies.
A. Yes.
Q. I believe you testified that the reimbursement for those 13 codes is based, in part, on the physician's acquisition cost, is that correct?

35

A. Yes.
Q. And can you tell me how Cigna determines the physician's acquisition cost?
A. It is information that we have through working with a -- I don't know technically what they are called, but essentially they are a pharmaceutical consultant group.
Q. And for those 13 J-codes, does Cigna reimburse at what it believes the physician's actual acquisition cost is?
A. Yes.
Q. Can you tell me instead what do you reimburse at?
A. It is reimbursed at the physician acquisition cost plus 20 percent of the AWP.
Q. And can you tell me the reasoning behind that reimbursement methodology?
A. The reasoning is that the -- for most of those J-codes, generic equivalents have been introduced for the drugs. They have -- with the introduction of generic equivalents, the physician acquisition cost has reduced significantly, and the -- so we have to make

36

sure that we cover physician acquisition cost, and we have chosen to add on an additional amount to make sure that we are paying above that amount in all situations.
Q. So you want -- so Cigna wants to insure that physicians are having their costs, their acquisition costs covered in all cases?
MR. ST. PHILLIP: Objection.
Q. Is that correct?
A. That is the intent.
Q. Does Cigna also intend to provide physicians with a reasonable margin above the acquisition cost?
A. It is not something that we have done is taken a position on what is considered reasonable, and margin, and the appropriateness of that.
MR. ST. PHILLIP: Can you read that answer back.
(The court reporter read back.)
Q. You mentioned that of the 13 drugs for which Cigna has applied this relatively new methodology, that many of them are -- have generic equivalents.
Can you tell me in a little more detail why these 13 drugs were chosen?

37

A. The 13 drugs were chosen because the prior reimbursement methodology, which is as I described otherwise, did not appropriately reflect the changes in the market pricing over the last -- my understanding it's been a couple of years that these generics have become available, and have been introduced to drive down the acquisition cost.
Q. Does Cigna look at the physician's acquisition cost for any drugs other than these 13 in setting reimbursement rates?
A. No.
Q. And can you tell me why not?
THE WITNESS: May I clarify the scope?
MS. SCHOEN: Please.
MR. ST. PHILLIP: You may.
A. I need to clarify that my responses have been related to injectable medications, not to vaccinations, toxoid immunizations.
So would you like to ask that question?
MS. SCHOEN: Can you read back the question.
(The court reporter read back.)

A. We haven't felt it's been necessary.
MR. ST. PHILLIP: We've been going awhile. When you find an appropriate breaking point, we'd like to take a break.
MS. SCHOEN: We can take a break now.
(Recess taken.)
Q. So going back to the Cigna national standard injectable reimbursement rate, those reimbursement rates are set on a drug-by-drug basis, is that correct?
A. They are set by HCPCS code.
Q. So they are set on a J-code by J-code basis?
A. That is correct.
Q. So Cigna would look at each J-code and make an individualized determination of the percentage below AWP or otherwise that it should be – the drug – that the J-code rather should be reimbursed at?
A. Yes. Each J-code is set individually.
Q. And just to make sure that I'm clear on your prior testimony, the decision of whether to reimburse based at AWP or below AWP by 15 percent or below AWP by 45 percent is all made by Tel-Drug?
A. Yes, I believe that is where discounts came

from.
Q. Can you think of any other place that those rates may have come from?
A. Pharmacy Operations within Cigna that are technically not of the Tel-Drug subsidiary but work very closely with them.
Q. And you're not aware of the factors that go into making the determination of the reimbursement rate?
A. That is correct, I have no knowledge.
Q. Now, we discussed briefly that one particular J-code may incorporate more than one NDC, is that correct?
A. That is correct.
Q. So if a physician submits a reimbursement claims form with only a J-code, under the – how does Cigna know what reimbursement to provide?
A. A reimbursement is set at the J-code level.
Q. Is it true that for each NDC, there may be a different AWP?
A. It is my understanding that that is correct.
Q. So how does Cigna determine which average

wholesale price to use when it's determining a reimbursement by J-code?
A. We obtain the average wholesale price at the J-code level. There's a methodology that the vendor – for lack of a better word – uses to look across the NDCs and come up with the appropriate average wholesale price.
Q. And when say the vendor, you mean a third party?
A. Yeah. It's not within Cigna.
MR. ST. PHILLIP: Could I clarify for a second?
MS. SCHOEN: Sure.
(Witness and counsel confer).
Q. After conferring briefly with counsel, do you have any –
A. Could you repeat the question.
MS. SCHOEN: Can you read back the question.
(The court reporter read back.)
A. Yes. The third party is First Data Bank.
Q. So First Data Bank provides you with an AWP

by J-code?
A. That is correct.
Q. And I believe you had testified that First Data Bank uses some methodology to arrive at that AWP by J-code, but you're not exactly sure of which methodology they use, is that correct?
A. No. They use a methodology.
My understanding of the methodology is as follows. They take all of the NDC's appropriate to bill underneath that J-code, and they break them into brand drugs and generic drugs, and take the average of the average wholesale prices of the brand drugs and the average of the average wholesale prices of the generics, and they use the lesser of the two of those numbers.
Q. And if there are no generics, then I would suppose they'd just take the average of the branded drugs?
A. That is my understanding, yes.
Q. And so when the – when Cigna is using the average wholesale price by J-code for its national standard injectable reimbursement rates, you're not

42

actually using the average wholesale price that relates to a particular NDC unless that NDC is the only NDC for a particular J-code?
MR. ST. PHILLIP: Objection.
You can answer.
A. That is correct.
Q. And going back to the other methodology for reimbursing physicians for pharmaceutical products, the AWP based methodology, is that based on J-code, or is that based on an NDC?
A. I want to clarify. You're talking about the rate exhibit when it says a certain percentage of AWP, are those AWPs based on J-code versus NDC?
Q. Right.
A. The reimbursement is set at the HCPCS level, the J-code level.
Q. So then would I be correct to say that if I looked at Cigna's rate exhibits for all pharmaceuticals that would be included under the rate exhibits, the reimbursement rate would be set by J-code, not by NDC?
MR. ST. PHILLIP: Objection.
A. The -- it is always done by the appropriate

43

coding. It's not done by NDC. It is done by HCPCS code or CPT code, whatever is appropriate for the physician to bill according to the industry standard coding requirements.
Q. So in the approximate 50 percent of the cases where the rate exhibit is based on an AWP based reimbursement, is the AWP referenced in that reimbursement the AWP for a particular J-code, or is it the AWP for a particular NDC?
A. AWP for a particular J-code.
Q. So once again, if there are multiple NDCs for a particular J-code, the AWP that would be used would be determined by First Data Bank, as you have described, by averaging the different AWPs for the different NDCs in that J-code, is that correct?
A. When we have a contract that we base the reimbursement of injectables as a percentage of AWP, those AWP amounts come from the First Data Bank.
Q. Are you aware that First Data Bank provides AWPs by NDC?
MR. ST. PHILLIP: Objection.
A. I can only assume that they do. I do not

44

know for certain.
Q. But the AWPs you use and First Data Bank for your rate exhibits are the ones that you've described previously where First Data Bank would average the AWPs for a J-code?
MR. ST. PHILLIP: Objection. It's really been asked and answered, but if you want to elaborate --
A. Yes. It's -- the AWP is set by J-code using the method described earlier about averaging the different AWPs across the NDCs.
Q. Prior to 2001, are you aware of what methodologies Cigna used to reimburse providers for pharmaceutical products?
MR. ST. PHILLIP: Objection to form.
You can answer.
A. In my conversations with colleagues who have knowledge about that time, it is my understanding that the reimbursement was as I have described, meaning that it's per the contracting terms. It's -- those contracting terms can take on different forms.
Prior to 2002, the national standard did

45

not exist, so that would not have been an option. So the options prior to that would have just been AWP based and percentable charges.
Q. If I were to go to the claims data for Aetna, would -- how would I tell if a particular reimbursement was based on AWP or it was based on a percent of billed charges?
MR. WADE: You asked if she went to an Aetna claim.
MS. SCHOEN: Excuse me?
MR. WADE: You asked if she went to an Aetna claim.
MS. SCHOEN: I'm sorry, I don't mean Aetna. I mean Cigna.
A. By looking at a claim, you could not tell.
Q. So can you just describe to me what I would have to do to find that out?
A. You would have to find out what the contracting terms are.
Q. Prior to 2002, do you have an idea of what percentage of reimbursement to providers was based upon the percent of billed charges as opposed to AWP?

46

A. I do not know.
Q. Do you know if that percentage would have changed over time from 1991 to 2002?
A. I do not know.
Q. Does Aetna –
MR. ST. PHILLIP: Cigna.
MS. SCHOEN: Sorry.
Q. Does Cigna have any – strike that.
Does Cigna make any attempts to encourage physicians to utilize Tel-Med – Tel-Drug?
MR. ST. PHILLIP: Objection to form.
A. Yes.
Q. And can you tell me how Cigna does that?
A. Through written communications to the providers.
Q. Any other ways?
A. I do not know for certain, but I would expect that it was included within the Website that we have for the practitioners.
Q. But Cigna does not require physicians to use the Tel-Drug service?
A. That is correct.

47

Q. When the rate -- when the reimbursement for pharmaceutical products and the rate exhibit is based on average wholesale price, is that reimbursement rate set for all drugs together as a lumped unit, or would certain individualized drugs sometimes be subject to separate negotiations and have a separate reimbursement rate?
MR. ST. PHILLIP: Objection to form.
A. I understand, from what I have seen in contracts, all the injectables would be reimbursed at the same percent AWP. I have not seen a contract where we've varied that percentage by particular J-code.
Q. And what other categories of drugs would there be in the rate exhibits besides the injectables that you've referred to?
A. Immunizations and vaccinations.
Q. Any others?
A. No.
Q. Do you have an understanding of why physicians pay for the drugs that they may administer in an office?
MR. ST. PHILLIP: Objection.

48

A. No.
Oh, I do have to clarify that one. On injectables, no. On the immunizations, we have more recently, very recently actually, tried to get information by talking with the manufacturers of the immunizations that are able to sell directly to the doctors. Some manufacturers do that and others do not.
Q. So in those cases, you might have been able to obtain estimates of what the physician's office might pay for the drugs?
A. Yes.
Q. Have you ever undertaken a similar inquiry with regard to injectables?
A. No.
Q. And do you know why not?
A. No.
Q. Do you know if – strike that.
Have you ever looked at the prices that Tel-Drug pays for injectables?
A. No. I have no knowledge what Tel-Drug's acquisition costs are.
Q. Have you ever considered asking Tel-Drug what

49

its acquisitions costs were in order to utilize that information in negotiations with physicians?
MR. ST. PHILLIP: Objection.
A. I personally have not considered that, but it's possible perhaps that people that were involved prior to my tenure might have considered that.
Q. Would that yield information that would be useful in negotiations with physicians?
MR. ST. PHILLIP: I'm just going to object insofar as there's been no foundation of the corporate relationship, and so the control between the various companies, and there hasn't been any foundation for that, so go ahead.
MS. SCHOEN: The witness did testify that Tel-Drug was a subsidiary of Cigna.
MR. ST. PHILLIP: The witness hasn't been authorized to testify about the corporate structure, so to the extent that testimony has been given, it hasn't been consented to by the company.
MS. SCHOEN: I'll start – I'll ask a

50

new question.
Q. Is the reason that Cigna has not acquired this information from Tel-Drug because the information would, in fact, not be useful in its negotiations with providers?
A. No.
Q. Then what would the reason be?
A. We haven't done it. We haven't — it hasn't been a consideration.
Q. But presumably if it would yield savings for Cigna, in pharmaceutical reimbursement, you would have done that?
MR. ST. PHILLIP: I ask the witness not to guess.
A. If we knew Tel-Drug's acquisition costs, it would just be another factor to consider in setting reimbursement. It's not that it would necessarily impact the reimbursement to physicians, because there may be other valid reasons why we should sell it at a different level. So there may or may not be savings from knowing what Tel-Drug's acquisitions costs are.
Q. I think that you were telling me earlier

51

about the competitive nature of negotiations.
Would the competitive nature of negotiations be one reason why that information may not be -- may not impact the ultimate reimbursement rate?
A. Certainly.
Q. Does Cigna maintain its contracts with providers in the regular occurrence of its business?
MR. ST. PHILLIP: I'm going to object. The deposition topic No. 25 which reads, the authentication and knowledge of all documents produced in response to Defendants' subpoena, and the extent to which such production is responsive to the Defendants' demands was excluded by the Magistrate Judge's ruling.
As a result, Cigna does not consent to have this witness testify concerning the authentication of documents.
MS. SCHOEN: Well, unfortunately at this stage, we have no documents to authenticate because Cigna has produced no contracts with providers. So I'm trying to determine whether such contracts exist and are

52

maintained so that we can then call for their production.
MR. ST. PHILLIP: That's okay. We don't consent to have this witness testify about that.
MS. SCHOEN: Are you instructing her not to answer this question?
MR. ST. PHILLIP: No.
THE WITNESS: Can you repeat the question, please.
(The court reporter read back.)
A. It has a standard business practice to maintain contracts with providers.
Q. And can you tell me where those contracts are maintained, if you know?
MR. ST. PHILLIP: Same objection.
A. No response on that one.
Q. You don't know?
A. I don't have enough information to respond.
Q. Are you aware that some injectable products can be obtained through a retail pharmacy network?
A. No, I do not have good knowledge about how

53

physicians acquire their injectables.
MR. ST. PHILLIP: Can we confer for a second?
MS. SCHOEN: Sure.
(Witness and counsel confer).
A. Counsel has clarified what he thought the question was. So let me say that it is my understanding that people can go to the local pharmacy and get certain injectable medications.
Q. And do you have an understanding whether the reimbursement that Cigna would provide to the pharmacist for dispensing that injectable medication would be the same as the reimbursement that Cigna would provide to a provider who dispensed that and administered that injectable medication?
MR. ST. PHILLIP: Objection.
A. I do not know.
Q. And would a variation between those two rates be a product of what you've described to me earlier as the negotiation process with a physician's group that results in varying rates of reimbursement?
MR. ST. PHILLIP: Objection. Lack of

54

foundation. It calls for speculation.
You can answer.
A. There are negotiations with provider groups, and there are also negotiations with pharmacies, and those negotiations will yield the appropriate result for reimbursement, and I know on the physician's side, it does mean there are varying levels of reimbursement for the same services to different physicians.
Q. When did you first become familiar with the term average wholesale price?
A. It was -- I would have become familiar with average wholesale price either during the time I was in college or in taking the actuarial exams, so prior to 1996.
Q. And can you tell me what your current understanding of AWP is?
A. My current understanding about what average wholesale price is, it's a number that's used as a benchmark, but I do not have -- and it's a very frequently used benchmark in the pharmaceutical industry. I do not know specifics about how it was calculated.

55

Q. Are you familiar with the term wholesalers acquisition cost or WAC?
A. I have become familiar with that term.
Q. Do you have any understanding of whether there's a relationship between a WAC price and an AWP price for a particular drug?
A. My limited exposure is that there is not a consistent relationship between WAC and AWP across the NDCs. So in other words, I do not think that WAC is always a set percentage of AWP and all NDCs.
Q. Do you have any understanding of whether the AWP bears any relationship to the actual acquisition cost of drugs?
MR. ST. PHILLIP: Object to the form.
A. Whose acquisition cost?
Q. Acquisition costs generally.
MR. ST. PHILLIP: If you can answer that, go ahead.
A. I don't think I can answer that one.
Q. What about Cigna's acquisition costs?
A. Can you please restate the whole question?
Q. Do you have any understanding as to whether

56

there's a relationship between the average wholesale price and Cigna's acquisition cost for pharmaceutical products?
MR. ST. PHILLIP: All pharmaceutical products?
MS. SCHOEN: Let's start with all, and then we can -- if you only know for injectables, then that's where we'll go.
A. In what I do, that is outside the scope of what I do, because I work on the reimbursement to practitioners. I'm not involved with the acquisition of pharmaceutical drugs and do not have that particular knowledge that is relative to the pharmacy operations area.
Q. So when you, in your work, use the average wholesale price as a benchmark, you don't have any expectation that it bears any particular relationship with the actual acquisitions costs because that's a separate thing --
MR. ST. PHILLIP: Objection to form.
Q. -- is that correct?
A. Yeah. I do not know that the acquisition

57

cost has a consistent relationship to the AWP. My understanding is that the acquisition cost is either less than or equal to the AWP.
Q. And where is that understanding from?
A. That understanding comes from my exposure to AWP through my education and training, and really through, over the last couple of years, just being around and listening to what's going on in the industry and what's going on at Cigna.
Q. Do you have any involvement or understanding of the reimbursement provided by Cigna to hospitals for pharmaceuticals administered in the hospital outpatient department?
A. That reimbursement would be based on the contractual terms.
Q. So once again, it would be based on rates that were determined through a process of negotiation with a hospital and a hospital group?
A. Yes.
Q. To your knowledge, has Cigna ever experienced a situation where a physician's practice group projected Cigna's rate exhibit rates?

58

A. There have been physician groups that have not accepted our proposed rate exhibits.
Q. And what happens then?
A. Either we come up with a new proposal through the negotiation process or the provider -- we do not contract with the provider, so they are not a part of our network.
Q. And what determines which approach Cigna takes?
MR. ST. PHILLIP: Objection.
A. What is the group demanding; how much level of reimbursement is affordable; and is there a particular need for that provider group in our network, because certain specialties where we make sure we have to have certain physicians -- a certain number of physicians in our networks to insure an appropriate access of care for our members.
Q. So would it be correct to say that in order to provide a plan that is -- that appeals to clients like employer groups, Cigna has to work to maintain a comprehensive network of providers?
MR. ST. PHILLIP: Objection.

59

A. To have sellable products, we do have to work to maintain competitive networks.
Q. Does Cigna ever approach a physician's group with a take it or leave it contract? In other words, here's what our offer is, and we won't deviate from it at all?
A. Yeah.
Q. Can you tell me approximately in what percentage of cases does that happen as opposed to the negotiation process?
MR. ST. PHILLIP: Over what period of time?
MS. SCHOEN: Well, let's start with 2001 through the present.
A. I do not know.
Q. Are you familiar with -- strike that.
Do providers -- physician's groups or physicians solicit bids from Cigna?
MR. ST. PHILLIP: Objection.
A. What do you mean by bid?
Q. Say a proposal for a contract between Cigna and that group, for that group to become a part of the

60

Cigna network.
A. Yes. I'm sure there have been situations where provider groups have approached us to become members of the Cigna network.
Q. Are you aware of whether Cigna provides reimbursement for the administration of a particular drug in a physician's office?
A. We do, at least during my tenure and my knowledge. Prior to like the 2001 time frame, I do not have knowledge.
Q. When Cigna considers the reimbursement for deposition administration fee for service, can you tell me how that fits into the negotiation process that we've been discussing?
MR. ST. PHILLIP: I'm just going to make an objection based on the exclusion of deposition topic No. 15, which deals with the area of negotiation between the reimbursement of the drug itself and the administrative service. The question is not precisely in there, so I'll allow the witness to answer it, but you're getting close.

61

A. The reimbursement with our provider groups, when negotiating, is considered in total, so it's the final total contract that may be decided -- that will be decided upon, and there are trade-offs made between the different services as you go through the process of negotiation and compromise to get to a solution that is agreeable to both parties.
Q. And would that statement be true for all of the line items in the rate exhibit?
MR. ST. PHILLIP: Objection.
Q. In other words, you're looking at all the line items in a rate exhibit together and the total package -- not pulling out one line and just looking at that -- pulling out one segment and looking at that?
MR. ST. PHILLIP: Same objection.
A. The negotiations are done looking across the entire range of services that the provider groups provide to the members, and during those negotiations there are trade-offs to get to a final compromise solution between ourselves and the provider group, and during those negotiation discussions, it is -- it very much happens that they talk about an individual line

62

item.

But when the bottom line is set, it's what is the overall level of reimbursement. That's what both parties have to get comfortable with.

Q. So could there ever be a case where Cigna may agree to a higher reimbursement for the -- for injectable drugs, for example, and -- in exchange for a lower reimbursement for the physician's administrative fee?

MR. ST. PHILLIP: I think actually that question is right at the heart of this, so we'll object based on Magistrate Judge's exclusion in paragraph 15. But I'll allow the witness to answer the question and preserve our right to move to strike.

MS. SCHOEN: For the record, we clearly disagree on that, but to move things along --

A. That could be a potential trade-off that does happen during the negotiation process.

Q. From 2001 to the present, do any of the reimbursement rates that Cigna uses rely on Medicare's reimbursement rates?

63

A. For what services are you asking that question of?

Q. In particular, drugs?

A. We have not based our reimbursement of any injectable medications based on what Medicare pays.

MR. WADE: Estella, I'm sorry to interrupt you. How much longer do you think you'll be with Jill?

(Discussion off the record.)

(Recess deposition at 3:00 PM.)

(Deposition resumed at 4:05 PM.)

Q. Do you know if Cigna owns any physician groups?

A. Yes, one.

Q. And can you tell me where that group is located?

A. Phoenix, Arizona.

Q. And has -- do you know how the physicians in that physician group acquire pharmaceutical products that they administer to patients?

A. I have no idea.

Q. You don't know whether they -- that physician group purchases the pharmaceutical products from a wholesaler or a manufacturer?

64

A. No, I do not know.

Q. Have you ever considered looking at the -- that physician group's acquisition costs for pharmaceutical products?

A. No.

Q. We spoke earlier about the average wholesale price and about pricing reporters generally like First Data Bank?

A. Yes.

Q. Do you know of other pricing reporters besides First Data Bank?

A. I've heard of the name Redbook, and I'm aware that our pharmacy area uses a system called Argus, but I've recently learned that the numbers in Argus for AWP are from First Data Bank.

Q. Do you have an understanding that the AWPs for a particular drug may be different in First Data Bank versus Redbook?

MR. ST. PHILLIP: Objection.

A. Yes. I have learned that they are different.

65

Q. Can you tell me how you learned that?

A. Because we've had contractors -- provider groups have come back to our contractors who have called me and have told me such, because they like to quote a different number as AWP when trying to negotiate to the right amount.

Q. So in the negotiation process, in the context of a negotiation process, a provider might tell you or someone else at Cigna that the Redbook has a different AWP than First Data Bank; is that what you're saying?

A. I don't think they necessarily tell us that the numbers are different, but they quote an AWP number, and we tell them it's not the same as ours or we tell them it is the same as ours.

Q. But the AWP that Cigna uses is always the First Data Bank AWP?

A. That is correct.

Q. Do you have any other knowledge of why First Data Bank might have a different average wholesale price listed than another pricing service?

A. No.

Q. Earlier we also spoke of your understanding

66

of the term average wholesale price.
I wonder if you could tell me if your understanding of that term has changed at all over time or has it been static?
A. It's been pretty static. I can't -- when I first learned about AWP through my studies in my very early career when I started becoming more involved, it had the same meaning to me.
Q. And how is AWP relevant to your studies?
A. To pass my actuarial exam, we had to have some basic understanding of products, healthcare products, life insurance products and different things, so there's a lot of -- wide scope of knowledge that you have to pass the exams.
Q. So this was a general actuarial exam, but it required some particularized knowledge about the healthcare industry?
A. Yes.
Q. And I believe you testified earlier that you don't know the prices that pharmacies may pay to acquire injectable drugs; is that fair?
A. That's correct.

67

Q. Do you have any understanding of -- strike that.
Do you have any understanding of whether the price that pharmacies pay for injectable drugs bears any relationship to the average wholesale price?
A. I'm sorry, you asked if I understand if the acquisition cost of what group? Pharmacies?
Q. The acquisition costs of injectable drugs by pharmacies bears any relationship to the average wholesale price?
A. It is my understanding that there is no consistent relationship to average wholesale price, but that acquisition of drugs by pharmacy's providers is typically at less than or equal to the average wholesale price.
Q. At the same time you presume that pharmacies are -- providers are acquiring the pharmaceutical products at a price that's less than the price that Cigna reimburses that provider?
MR. ST. PHILLIP: Objection.
Don't presume.
A. I'm not sure I understand the whole question.

68

Q. Sure. I'll rephrase it.
Isn't it correct that when Cigna reimburses a provider for a pharmaceutical product, that Cigna will presume that that provider has purchased that product for a price that's less than what the reimbursement is?
MR. ST. PHILLIP: Same objection.
A. We like to be able to cover the physician's acquisition cost. However, we are operating in a competitive industry, and if the physicians are not purchasing at lower rates that are available in the market, so they're paying an amount that's higher than they can buy the same thing from somebody else, then it's potentially possible that our reimbursement can be less than their acquisition cost, because we are a competitor market driven company. It's the marketplace we operate in.
Q. And any such loss that the provider may incur for a pharmaceutical product, reimbursement could potentially be made up by Cigna's reimbursement to that provider for another line item on the rate exhibit; isn't that correct?

69

MR. ST. PHILLIP: Objection. Calls for speculation.
A. That is correct.
Q. Have some providers threatened to leave the Cigna network during the negotiation process around the rate exhibit reimbursement rates?
A. That can happen during negotiations, yes.
Q. And like you testified earlier, would that either lead Cigna to offer perhaps a higher reimbursement rate or lead Cigna to tell the physicians group that the rates are nonnegotiable?
MR. ST. PHILLIP: Objection.
A. If the provider is unsatisfied with the reimbursement, there could be other alternatives negotiated, or there may not be a contract with that provider.
Q. You've testified that in your current role, one of your many functions is to analyze the reimbursement rates provided to providers?
A. That is correct.
Q. And can you tell me a little bit more about what type of analysis that you engage in?

70

A. The analysis that we do is to look at part reimbursement as well as proposed reimbursement and how much of an increase that is going to be, and what is that overall impact going to be on the amount of costs for our members.
Q. Do you do that analysis on a physician's group by physician's group basis?
A. That is done, yes, basically a physician group-by-physician group. It's whenever we have a negotiation. We could end up doing multiple analyses depending on how many different scenarios there are within the negotiations that we have.
Q. So if there are different rounds of negotiations that lead to different offers for rate exhibits on the table, you might do an analysis for each different rate exhibit before it's offered?
A. Yes.
Q. And are you looking at any in the -- in your analysis, are you looking at any information that would let you know whether the rates that you're considering offering this provider are competitive in the marketplace?

71

A. Well, sometimes as part of our analysis, we will look at what we are reimbursing other physicians for the same services to help us understand is that competitive with our other negotiations. My team can do that.
Contract negotiators might have discussions with providers about our reimbursement versus the reimbursement that they might get from another carrier.
Q. And would Cigna take into account what the providers have told them about what they may be getting from another carrier?
A. Indirectly, yes. As it -- we make the decisions -- it's really the outcome about what the provider is going to be reimbursed is the outcome of the negotiation process. It's back and forth, give and take, and there's many factors to consider.
Q. Are injectable drugs included on the Cigna formulary?
A. I do not know.
Q. Do you know whether Cigna receives rebates from pharmaceutical manufacturers for injectable drugs?

72

MR. ST. PHILLIP: What time frame?
MS. SCHOEN: Let's start with currently.
A. I do not know.
Q. What about historically? Do you know if Cigna has, in the past, received rebates from pharmaceutical manufacturers for injectable products?
A. I do not know.
Q. In the negotiation process with physicians groups, who are Cigna's competitors?
MR. ST. PHILLIP: Objection.
You can answer.
A. Our competitors are the carriers who are providing health care insurance coverage to other members, to other people in the population. So there's numerous competitors out there.
Q. Do you see pharmacy benefit managers as competitors in this negotiation process with physicians?
MR. ST. PHILLIP: Objection.
A. No, I do not see them as competitors as it relates to a relationship with physicians.
Q. I may have asked you this already, but given

73

the time lapse, I'll go ahead and ask you again.
Do you have any understanding of whether providers may receive rebates from pharmaceutical manufacturers for injectable drugs?
A. I do not know.
Q. What about for any other type of drugs that a physician may administer in the physician's office?
A. I do not know.
Q. I believe you testified that it's your understanding that providers may pay the average wholesale price or some percentage below that for pharmaceutical products administered in their office, correct?
MR. ST. PHILLIP: Objection.
A. Could you please repeat the question.
Q. I believe it was your testimony that providers pay average wholesale price or some percentage below average wholesale price for pharmaceutical products administered in an office, is that correct?
A. That's my understanding.
Q. Are you familiar with the term wholesaler's

74

acquisition costs?
A. Yes.
Q. And what is your understanding of that term?
A. That it is -- it represents a rate amount that is supposed to be the wholesaler's acquisition cost, but exactly how it all gets calculated, I do not know. What I do know about it is that it -- every situation -- I've never known it to be above AWP, so less than AWP, but exactly what the number is doesn't have a direct relationship with AWP.
Q. Would you say that Cigna has an understanding that providers need to make a profit margin in order to stay in business?
MR. ST. PHILLIP: Objection.
A. Your question was if providers need a profit margin to stay in business?
Q. Is that correct?
A. Yes.
Q. And that as a general matter, Cigna assumes that the reimbursement rates that it provides providers will allow the physicians to make a fair and reasonable margin and stay in business; isn't that correct?

75

MR. ST. PHILLIP: Objection.
THE WITNESS: Could you repeat the question.
(The court reporter read back.)
A. The reimbursement to the providers is the result of the negotiations, and while as we cannot determine if that reimbursement will allow us -- will allow the provider to make a profit or not, it is in Cigna's interest that providers do stay in business, because they are the ones that are servicing our members.
Q. Does Cigna have a preference for the site that a physician administered drug is administered?
MR. ST. PHILLIP: I'm sorry, can you read that back.
(The court reporter read back.)
A. To my knowledge, no. The -- we want doctors following standard medical protocols, but I do not know of a specific statement of any sort related to that matter.
Q. For example, if a particular drug could be administered in a physician's office but could also be

76

administered in a hospital outpatient department, does Cigna have any preference over the site of care?
MR. ST. PHILLIP: Objection, insofar as it calls for an across the board answer. Go ahead.
A. The answer to that is that our preference, if it was medically appropriate to do so, for that injectable to be administered in a physician's office because it generally is better for the member as well as the lower medical costs.
Q. And do you know why there are lower medical costs in a physician's office as opposed to a hospital outpatient department?
A. That would be because of the overhead and facility costs that is associated with the outpatient facilities.
Q. So Cigna's reimbursement to the hospital would generally be greater than its reimbursement to a physician's office for administration of the same product?
MR. ST. PHILLIP: I'm going to object.
Q. Is that correct?

77

MR. ST. PHILLIP: The court excluded deposition topic No. 18 which reads, whether and to what extent you provide different reimbursement rates for subject drugs when they are administered in providers' offices rather than in hospitals, including your clients' rationale for doing so or not doing so. The Magistrate Judge excluded that testimony, so I instruct the witness not to answer.
MS. SCHOEN: Well, clearly we disagree and feel that this deposition topic falls under other areas.
For purposes of moving forward today, we will move forward.
Q. Do you have any knowledge that doctors have conspired with drug manufacturers to inflate drugs' average wholesale price?
MR. ST. PHILLIP: Object insofar as it calls for a legal conclusion, but you can answer.
A. I have no knowledge.

78

Q. Do you have any knowledge of any activities undertaken by any drug manufacturers to inflate the average wholesale prices for their drugs?
MR. ST. PHILLIP: Same objection.
Go ahead.
A. I have no knowledge.
MS. SCHOEN: I think if I could, I'm probably about to wrap up here. I have to look over my notes.
Ed, are you going to have any questions of this witness?
MR. NOTARGIACOMO: Yes, a few. Not too long.
MS. SCHOEN: I have just a couple more questions.
Q. How does Cigna determine whether it's achieving a competitive reimbursement level when negotiating with providers?
MR. ST. PHILLIP: Objection.
A. We try to find the most credible sources of information that we can, and sometimes we'll get information from the providers. We can also look at

79

what we paid to other providers for the same or similar types of services.
Q. So on occasion, Cigna uses external sources to assess its reimbursement levels to providers, is that correct?
MR. ST. PHILLIP: Objection.
A. Yes. The assessments that we're able to do are -- that would really be external are not to specific provider groups but rather to the competitive position in the overall market.
Q. Does Cigna attempt to lower its negotiated rates with physicians over time?
A. Cigna tries to get competitive rates with physicians because we need to control the medical costs for our members. Sometimes that means competitive -- we give increases. Other times it means decreases.
Q. And does Cigna have a way of determining whether any increases or decreases of the reimbursement rate in an attempt to be competitive have gone too far or gone not far enough in the case of an increase?
A. We don't have any specific way to assess that beyond a retrospective look at the same type of

80

information we would have had when we first made the decision.
MR. ST. PHILLIP: It relates to the bankruptcy filings of the physicians groups.
MS. SCHOEN: I have no further questions at this time.
Ed?

CROSS EXAMINATION
BY MR. NOTARGIACOMO:
Q. Ms. Herbold, I'll be very brief. If you can't understand -- my name is Ed Notargiacomo. I'm not sure if I introduced myself to you prior to today. I represent the Plaintiff in this action, and I have a few more questions.
This afternoon, I guess, and partially this morning -- I'm losing track at this point -- you testified about -- I think it's payment to physicians for -- to physicians and physician groups for physician administered drugs provided to or administered to Cigna members; is that fair to say?
A. Could I ask that you repeat that question so

81

I make sure I understand it correctly.
MR. NOTARGIACOMO: I'm sorry, I couldn't hear.
(The court reporter read back.)
Q. It really is a preparatory question.
You testified today about the payment by Cigna to physicians for physician administered drugs, is that correct?
A. Yes.
Q. And in that you talked about two distinct time periods: One time period being pre-2002; is that correct?
A. Could you repeat that.
Q. One of the time periods we talked about is the pre-2002 time period?
A. My testimony today related primarily to the period like 2002 and later. I provided a little testimony related to prior to 2002 based on my conversations with people that have knowledge of that time.
Q. Still sticking with the pre-2002 time period, based on your conversation with people in Cigna who

82

have knowledge of that period, is it your testimony that Cigna reimburses the physician at a rate, a negotiated rate, but a rate that was a percentage off of -- expressed as a percentage off of average wholesale price or AWP, is that correct?

MS. SCHOEN: Objection to form.

MR. ST. PHILLIP: If you could do that one more time, we just increased in volume so we'll be able to do it.

Q. Sticking with the period from 2002 earlier, I'm basing your conversations with people at Cigna, was it your testimony today that Cigna reimburses physicians or reimbursed physicians at a price that was a discount off of average wholesale price?

MS. SCHOEN: Objection to form.

Q. Is that correct?

A. Prior to 2002, Cigna reimbursed physicians at the negotiated rates. Those negotiated rates were commonly expressed as percent of AWP. They may have also been expressed as a percent of billed charges, but those are the only two approaches that I'm aware of.

Q. And then for the period from 2002 on, you

83

said that approximately 50 percent of reimbursement is done at or under that same methodology as a negotiated price off of the average wholesale price or as a percentage of bill charged; is that correct?

A. That is correct.

Q. And the other 50 percent is based on Cigna's national standard pricing list, is that correct?

A. Yes, that is correct.

Q. And even the prices on Cigna's national standard pricing list are expressed as a percentage off of average wholesale price, is that correct?

A. Yes, some of them are. Not all of them are.

Q. Some of them are.

The ones that aren't, are you referring specifically to the 13 -- the drugs that fall under the 13 codes that are based --

A. Yes.

Q. -- on something different?

A. Yes.

Q. And those exceptions, those 13 codes, the reimbursement methodology for those drugs is based on acquisition costs, but isn't it true that it also has a

84

part of the formula that is also based on average wholesale price, is that correct?

A. That is correct.

Q. Would you agree with me that Cigna's goal is to get the best -- when negotiating with physicians about the reimbursement for physician administered drugs, would you agree that Cigna's goal is to get the best deal it can for itself while providing adequate reimbursement to physicians for the drugs it administers to its members?

A. Yes.

Q. And is it fair to say that Cigna expects that the doctors in its network to make a living primarily providing treatment to patients and not from large markups on those physician administered drugs?

MS. SCHOEN: Objection to form.

A. Could you please repeat the question.

Q. Sure.

Is it fair to say that Cigna expects that doctors in its networks are -- make their living primarily providing treatment to patients and the payment from providing treatment to patients and not

85

from large markups on prescription drugs that it administers?

MS. SCHOEN: Objection to form.

A. With respect to the reimbursement of practitioners for their services, we expect that the physician is negotiating with us and another carrier so that they can maintain sufficient profit margin to operate their business and stay in business. We don't have a specific expectation about exactly what their billed charges might be for a particular service because it's a difference between that billed charge and the reimbursement amount that I would call and refer to as a markup.

Q. When you use the term billed charge, what are you referring to?

A. What I'm referring to there is the fee amount that the physician would submit on the claim in order for the claim to get paid. It's -- another way to say it is it is the amount that the physician would charge for an indemnity member.

Q. Let's turn back to the 13 codes that we talked about a few minutes ago.

86

I believe you testified that one -- and correct me if I'm wrong -- that the reason that Cigna singled out these 13 codes for different treatment was the fact that there became available on the market generic forms of those drugs that were available at a cheaper price, is that accurate?

A. Yes, and let me clarify. Our change that we made was in reaction to the result of competitive market forces. Generic drugs were introduced that drove down the acquisition cost, the cost of the product in the marketplace.

Q. And the change -- were you finished?

A. Yes -- I'm finished, yes.

Q. And the change in the reimbursement for those codes that Cigna instituted, was that an attempt to bring physician reimbursements for those codes in line with the lower price available in the marketplace for those drugs?

A. Yes.

Q. So if Cigna had information that other drugs other than that 13 were available for a price that was significantly less than the reimbursement that Cigna

87

currently provides in its national standard price list, would Cigna take steps to try to bring the reimbursement rate that it provides down to the level that's available -- the level of reimbursement that's available to doctors who purchase in the marketplace?

MS. SCHOEN: Objection to form.

A. Cigna is trying to make sure that we maintain -- well, that we have competitive medical costs that we are able to sell our products and have members, and Cigna is -- also has an interest, as I've stated, in making sure that the providers can stay in business.

And in terms of applying that to the reimbursement for specific drugs, we made those changes reflecting the changes that were going on in the marketplace, and also what physicians were willing to accept for reimbursement.

I mean, another way of thinking about that is that we ranked the changes that we're aware of in terms of market price changes, but it also -- we have to factor in what is the reimbursement amount that physicians are willing to accept.

Q. You testified that -- when you were asked

88

whether Cigna understands what physicians paid for physician administered drugs, you just testified that Cigna didn't have an understanding of that.

Is that generally your testimony?

A. We don't have specific knowledge about it. The knowledge that we have is just based on what -- it's really based on we set a fee amount, and the providers come back and complain about it or they don't. So it's not that we understand their specific acquisition costs, but if our reimbursement is too low, we hear about it.

Q. I think you testified that one of the exceptions is some -- with respect to some manufacturers of immunization products.

Do you remember testifying about that?

A. I'm sorry, can you please repeat that question?

Q. Sure.

I think that you testified with respect to having had some contact with some manufacturers of immunization products?

A. Yes.

89

Q. And in that way learning what the physician acquisition price for immunization products -- at least some products are; is that accurate?

A. That is accurate. My prior comment was related to injectables. I'm sorry, I didn't clarify that.

Q. That's okay.

As with respect to the immunization products and the information that Cigna obtained with respect to those conversations, did that information then -- was that used by Cigna in determining what reimbursement it would provide to physicians for those immunization products?

A. That's a very interesting question. As I mentioned, it is in the recent past, and to be more specific, the last month and a half, that we have gotten that information, and we have yet to make a determination about exactly how we're going to set our reimbursement on immunizations going forward.

MR. NOTARGIACOMO: I have no other questions.

MR. ST. PHILLIP: I have none.

MR. WADE: None for me.
MS. SCHOEN: I have just a couple more questions.

REDIRECT EXAMINATION
BY MS. SCHOEN:
Q. The time period prior to 2002, you testified as to the reimbursement methodologies generally employed during that time period. One was a methodology based on the average wholesale price, and the other was billed charges.
My question goes to the reimbursement based on average wholesale price.
Can you tell me whether there was variability in the reimbursement percentage above or below AWP during the time prior to 2002?
MR. ST. PHILLIP: Objection. Asked and answered.
Go ahead.
A. I have no specific knowledge. However, I would have a hard time believing that there wasn't some variation as a result of provider negotiations.

MS. SCHOEN: No further questions.
MR. ST. PHILLIP: We're done.
(The deposition adjourned at 5:00 PM.)

CERTIFICATE

I, DIANA M. NOEL, a Registered Professional Reporter, Certified Realtime Reporter, Licensed Shorthand Reporter, and Notary Public duly commissioned and qualified in and for the State of Connecticut, do hereby certify that there came before me JILL S. HERBOLD, who was by me duly sworn and thereupon testified as appears in the foregoing deposition; that said deposition was taken by me stenographically in the presence of counsel and reduced to writing under my direction; that this deposition is a true record of the testimony given by the witness.

I further certify that I am neither attorney nor counsel for, nor related to, nor employed by any of the parties to the action in which this deposition is taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties hereto, or financially interested in the action.

IN WITNESS THEREOF, I have hereunto set my hand this 19th day of January, 2005.

DIANA M. NOEL, Notary Public
Registered Professional Reporter
Certified Realtime Reporter
Licensed Shorthand Reporter No. 199

My Commission Expires:
June 30, 2007